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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07278

7304

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Kent		MARYLAND		STATE Maryland		COUNTY Queen Anns	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		LENGTH OF STAY (In this place) 5 days		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown R.R. 1, 17x-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Kent & Queen Anne's				STREET ADDRESS (If rural give location) McGinnis Corner			
3. NAME OF DECEASED (Type or Print) (First) William (Middle) E (Last) Bradley				4. DATE OF DEATH (Month) July (Day) 14 (Year) 19 56			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 1895	9. AGE last birthday 64 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM ADDISON BRADLEY				14. MOTHER'S MAIDEN NAME SUSAN J. MASSEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 216-14-2559		17. INFORMANT & ADDRESS Mrs. Wm. Bradley Chestertown, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
606X IMMEDIATE CAUSE (A) Uremia				INTERVAL BETWEEN ONSET AND DEATH 4 days			
ANTECEDENT CAUSE(S) DUE TO (B) Probable polycystic kidneys and enlarged prostate.							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 7-12-56		19b. MAJOR FINDINGS OF OPERATION Bladder obstruction-enlarged kidneys		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7-10, 19 56, to 7-11, 19 56, that I last saw the deceased alive on 7-13, 19 56, and that death occurred at 5:40 A.M. from the causes and on the date stated above.							
SIGNATURE ac'sick				ADDRESS (Street, city, town, state) Chestertown, Md.		DATE SIGNED 7-16-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF JULY 16		NAME OF CEMETERY OR CREMATORY Church Hill Church Hill Ind.		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR July 18-1956		REGISTRAR'S SIGNATURE Clara S. Barnes		25. FUNERAL DIRECTOR'S SIGNATURE Edward Lane		ADDRESS Church Hill	

CERTIFICATE OF DEATH

IN THE CITY AND COUNTY OF BALTIMORE

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BUREAU V. 3

JUL 20 1956

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7305

CERTIFICATE OF DEATH

07279

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester Town</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Annes Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>			
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>ELLA</u> Last <u>Chambers</u>				d. STREET ADDRESS <u>17X-2</u>			
4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1956</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 28</u>	
9. AGE (In years last birthday) yrs. <u>11</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles Chambers</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Tull</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Mother</u>			
17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary atelectasis</u> DUE TO <u>762.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>prematurity</u> DUE TO (c) <u>pregnancies too close</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> <u>7 wks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 28, 1956</u> , to <u>July 8, 1956</u> , that I last saw the deceased alive on <u>July 8, 1956</u> , and that death occurred at <u>12:05 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Florence D. Joyce</u> M.D. <u>Worton, Md.</u>				DATE SIGNED <u>7/8</u>			
PHYSICIAN'S NAME (Type) <u>FLORENCE JOYCE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>JULY 9</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>CHESTER</u>		22d. LOCATION (City, town, or county) (State) <u>CHESTERTOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> ADDRESS <u>Church Hill</u>				24a. REC'D BY REGISTRAR <u>July 11-56</u>		24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, and cause of death. The form is filled out with handwritten text, which is mostly illegible due to the quality of the scan. Some legible text includes "JUL 16 1956" and "BUREAU V. S."

BUREAU V. S.

JUL 16 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 202

7306

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown			
c. LENGTH OF STAY IN 1b 50 Yrs.				d. STREET ADDRESS 223 S. Queen Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 223 S. Queen Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last RACHEL GOLDSBOROUGH				4. DATE OF DEATH Month Day Year July 14 1956 19			
5. SEX F.	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1876	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeping		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Galena Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph P. Davis				14. MOTHER'S MAIDEN NAME Mary Louise Butler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address 2109 Madison Ave. Balto. 17, Md. Mrs. Virginia Tabb			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 8, 1956, to July 14, 1956, that I last saw the deceased alive on July 13, 1956, and that death occurred at 6:00 a.m., from the causes and on the date stated above.							
ACTUAL SIGNATURE E. Kester M.D.				DATE SIGNED Rock Hall and			
PHYSICIAN'S NAME (Type) E. Kester							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 17/56		22c. NAME OF CEMETERY OR CREMATORY Chestertown Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Marvin V. Williams Chestertown, Md.				24a. REC'D BY REGISTRAR July 18-1956		24b. REGISTRAR'S SIGNATURE Clara S. Barnes	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 20 1956

RECEIVED

CERTIFICATE OF DEATH

7399

Reg. Dist. No.

07281

203

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall Rural</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near - Rock Hall</u>			
				d. STREET ADDRESS			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>B.</u> Middle <u>Grice</u> Last				4. DATE OF DEATH <u>July 26, 1956</u> Month <u>July</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 25, 1891</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Broker</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Marion S. Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>P. L. Grice</u>				14. MOTHER'S MAIDEN NAME <u>Mattie Turbibill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW I</u>		17. INFORMANT <u>Mrs. Geo. B. Grice</u>		Address <u>Rock Hall, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>334x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio sclerosis</u> DUE TO (c) <u>Cerebral Arterio sclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 2 -</u> , 19 <u>56</u> , to <u>July 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 26</u> , 19 <u>56</u> , and that death occurred at <u>5:10 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rock Hall, Md.</u> DATE SIGNED <u>July 27/56</u> ACTUAL SIGNATURE <u>Norbert C. Nitch</u> M.D. <u>Rock Hall, Md.</u> PHYSICIAN'S NAME (Type) <u>Norbert C. Nitch</u> <u>Rock Hall, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>				ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7/29/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>S. Wood</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

AUG 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7310

CERTIFICATE OF DEATH

67282

Reg. Dist. No. 202

1. PLACE OF DEATH o. COUNTY <u>Bent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Bent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Chestertown</u>				c. LENGTH OF STAY IN 1b <u>2 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Strong Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>(none)</u> Last <u>Haggerty</u>				4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 4, 1859</u>	
9. AGE (In years last birthday) yrs. <u>96</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York (State)</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Patrick Haggerty</u>				14. MOTHER'S MAIDEN NAME <u>Johanna unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs. R. Gerald Myers</u>		Address <u>Chestertown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory collapse</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Senility</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>20 years?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March</u> , 19 <u>54</u> , to <u>July</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 13</u> , 19 <u>56</u> , and that death occurred at <u>6:15 p.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u> DATE SIGNED <u>July 16, 1956</u>							
ACTUAL SIGNATURE <u>A. C. Dick</u> M.D. <u>Chestertown, Md.</u>				PHYSICIAN'S NAME (Type) <u>A. C. Dick</u> <u>Chestertown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 17, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Wells</u> ADDRESS <u>Chestertown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>July 18-1956</u>		24b. REGISTRAR'S SIGNATURE <u>Clara L. Barnes</u>	

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

08381

Reg. Dist. No. 303

7311

1. PLACE OF DEATH COUNTY <u>KENT</u> MARYLAND CITY OR TOWN <u>ROCK HALL</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>KENT</u> CITY OR TOWN <u>ROCK HALL</u> STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) <u>ELMER</u> (Middle) <u>H.</u> (Last) <u>HAGUE</u>				4. DATE OF DEATH (Month) <u>JULY</u> (Day) <u>27</u> (Year) <u>1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>2-7-1884</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TENANT FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Cyrilial Hague</u>				14. MOTHER'S MARDEN NAME <u>Sarah Millington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>220-26-3874</u>		17. INFORMANT & ADDRESS <u>Ms. Blanche Hague</u> <u>Rock Hall</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422. IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio Sclerosis Cerebral</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Myocarditis</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1</u> , 19 <u>56</u> , to <u>July 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 27</u> , 19 <u>56</u> , and that death occurred at <u>2 30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Robert C. Nitech</u>		M. D. <u>Rock Hall Maryland</u>		DATE SIGNED <u>7/31/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>7-30-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Paul</u>		LOCATION (City, town, or county) <u>Fairlee Md.</u>	
24. REC'D BY REGISTRAR DATE <u>7/30/56</u>		REGISTRAR'S SIGNATURE <u>Edmond Bringer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edmond Bringer</u>		ADDRESS <u>Church Hill</u>	

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

MARYLAND

COUNTY OF

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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BUREAU V. S.

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RECEIVED

TO BE FILLED IN BY THE REGISTRAR OF DEATHS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07283

7312

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GOLT</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GOLT</u>			
				d. STREET ADDRESS			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>J.</u> Last <u>HINES</u>				4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1956</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 22, 1882</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>GOLT, MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>SHADE JOHNSON</u>				14. MOTHER'S MAIDEN NAME <u>MARY DAVIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>GEORGE HINES</u>		Address <u>GOLT, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute heart failure</u> <u>591X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Degeneration of heart</u> (c) <u>Nephrosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>hr years -</u> <u>years -</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>56</u> , to <u>July 5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 1</u> , 19 <u>56</u> , and that death occurred at <u>1 A. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Millington, Md.</u> DATE SIGNED <u>7-6-56</u>							
ACTUAL SIGNATURE <u>Geza Koralewski</u> M.D.							
PHYSICIAN'S NAME (Type) <u>GEZA KORALEWSKI</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/8/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEW BETHEL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>GOLT MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Hollows</u>				ADDRESS <u>Millington, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7/6/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edward Hollows</u>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text, possibly "JOHN J. ..."]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>		<p>3. AGE [Faint text, possibly "45"]</p>	
<p>4. DATE OF DEATH [Faint text, possibly "1956-10-10"]</p>		<p>5. TIME OF DEATH [Faint text, possibly "10:00 AM"]</p>		<p>6. PLACE OF DEATH [Faint text, possibly "Home"]</p>	
<p>7. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>		<p>8. MANNER OF DEATH [Faint text, possibly "Natural"]</p>		<p>9. PLACE OF BIRTH [Faint text, possibly "Boston, Mass."]</p>	
<p>10. DATE OF BIRTH [Faint text, possibly "1911-01-01"]</p>		<p>11. PLACE OF BIRTH [Faint text, possibly "Boston, Mass."]</p>		<p>12. OCCUPATION [Faint text, possibly "Teacher"]</p>	
<p>13. MARITAL STATUS [Faint text, possibly "Married"]</p>		<p>14. NAME OF SPOUSE [Faint text, possibly "Mary J. ..."]</p>		<p>15. DATE OF MARRIAGE [Faint text, possibly "1935-06-15"]</p>	
<p>16. NAME OF PHYSICIAN [Faint text, possibly "Dr. J. ..."]</p>		<p>17. NAME OF FUNERAL HOME [Faint text, possibly "St. ..."]</p>		<p>18. NAME OF MINISTER [Faint text, possibly "Rev. ..."]</p>	
<p>19. NAME OF BURIAL PLACE [Faint text, possibly "St. ..."]</p>		<p>20. NAME OF CEMETERY [Faint text, possibly "St. ..."]</p>		<p>21. NAME OF INTERMENT [Faint text, possibly "St. ..."]</p>	
<p>22. NAME OF REGISTRAR [Faint text, possibly "John J. ..."]</p>		<p>23. NAME OF CLERK [Faint text, possibly "Mary J. ..."]</p>		<p>24. NAME OF ASSISTANT [Faint text, possibly "John J. ..."]</p>	

BUREAU V. 2

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07284

7307

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Worton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent and Queen Anne's</u>				STREET ADDRESS (If rural give location) <u>Worton Manor</u>			
3. NAME OF DECEASED (Type or Print) <u>Jesse Dixon Maxwell</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 23, 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 4, 1888</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-salesman Automobile</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Peru, Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jonathan Dixon Maxwell</u>				14. MOTHER'S MAIDEN NAME <u>Nora Cockley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>First World War</u>		16. SOCIAL SECURITY NO. <u>218-20-4367</u>		17. INFORMANT & ADDRESS <u>Mrs. J.D. Maxwell, Worton, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Acute pulmonary oedema</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Left ventricular failure</u>						<u>5 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Coronary artery disease</u>						<u>10 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 10, 1940, to July 23, 1956, that I last saw the deceased alive on 7-23-56, and that death occurred at 8:03 A.M. from the causes and on the date stated above.							
SIGNATURE <u>ac Sick</u>		M. D. <u>Chestertown, Md.</u>		ADDRESS (Street, city, town, state) <u>near- Chestertown, Md.</u>		DATE SIGNED <u>7-23-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 26, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Saint Paul Cem.</u>		LOCATION (City, town, or county) <u>near- Chestertown, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Wells</u>		ADDRESS <u>Chestertown, Md.</u>	

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Pern, Indians

Retired-salesman Automobile

BUREAU V.

JUL 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. *202*

7308

07285

1. PLACE OF DEATH o. COUNTY <i>Kent</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Kent</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chestertown</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rock Hall</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kent & Queen Anne's</i>		d. STREET ADDRESS <i>Rock Hall</i>	
3. NAME OF DECEASED (Type or print) <i>BABY BOY MORRIS</i>		4. DATE OF DEATH <i>July 27 1956</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 27, 1956</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.S.</i>	
13. FATHER'S NAME <i>Albert Romain Morris</i>		14. MOTHER'S MAIDEN NAME <i>Ruth Miriam Parsons</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Ruth M. Morris</i>		Address <i>Rock Hall Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Unknown - but probable congenital heart lesion</i> 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Premature birth</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 27, 1956</i> to <i>July 27 1956</i> , that I last saw the deceased alive on <i>July 27, 1956</i> , and that death occurred at <i>5:00 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert W. Farr</i>		DATE SIGNED <i>7/27/56</i>	
PHYSICIAN'S NAME (Type) <i>ROBERT W. FARR</i>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/28/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Chester Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Chestertown, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		24a. REC'D BY REGISTRAR <i>July 28-56</i>	
ADDRESS <i>Chestertown, Md</i>		24b. REGISTRAR'S SIGNATURE <i>Clara L. Barnes</i>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		65		M		W		JUL 20 1914		AT HOME	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT		BURIAL PLACE	
1000 N. W. 10th St., Wash. D.C.		Retired		Heart Disease		Natural		Dr. J. H. Smith		Catholic Cemetery	
FATHER'S NAME		MOTHER'S NAME		BIRTH DATE		BIRTH PLACE		EDUCATION		MARRIAGE DATE	
JAMES H. HARRIS		MARY J. HARRIS		JUL 15 1849		VA.		Common School		JUL 15 1875	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		DECEASED'S OCCUPATION		DECEASED'S EDUCATION		DECEASED'S MARRIAGE		DECEASED'S BIRTH	
Farmer		Homemaker		Retired		Common School		JUL 15 1875		JUL 15 1849	
FATHER'S DEATH DATE		MOTHER'S DEATH DATE		DECEASED'S DEATH DATE		DECEASED'S DEATH PLACE		DECEASED'S DEATH CAUSE		DECEASED'S DEATH MANNER	
				JUL 20 1914		AT HOME		Heart Disease		Natural	
FATHER'S DEATH CAUSE		MOTHER'S DEATH CAUSE		DECEASED'S DEATH CAUSE		DECEASED'S DEATH MANNER		DECEASED'S DEATH MEDICAL ATTENDANT		DECEASED'S DEATH BURIAL PLACE	
				Heart Disease		Natural		Dr. J. H. Smith		Catholic Cemetery	

BUREAU V.

JUL 30 1914

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

67286

7313

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>				c. LENGTH OF STAY IN lb <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>W. Miller Strong</u>				4. DATE OF DEATH Month Day Year <u>July 29, 1956</u> 19 <u>19</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29, 1889</u>	9. AGE (In years last birthday) yrs. <u>67</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edgar H. Strong</u>				14. MOTHER'S MAIDEN NAME <u>Rose V. Crouch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT Address <u>Mrs Marie Strong Rock Hall, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>diabetes mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 14, 1956</u> , to <u>July 29, 1956</u> , that I last saw the deceased alive on <u>July 28, 1956</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norbert C. Nitsch</u> M.D.				ADDRESS (Street, city or town, state) <u>Rock Hall Md</u> DATE SIGNED <u>7/30/56</u>			
PHYSICIAN'S NAME (Type) <u>Norbert C. Nitsch Rock Hall, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 1, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>near - Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Wells</u>				ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Aug 1/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>S. Wood Burger</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Race		5. Date of death		6. Time of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	

7314 CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall			
c. LENGTH OF STAY IN life				d. STREET ADDRESS Greys Inn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Greys Inn				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LOUISE THOMPSON				4. DATE OF DEATH Month Day Year July 25 19 56			
5. SEX F.	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 8 1872		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? u.s. A.	
13. FATHER'S NAME James Thompson				14. MOTHER'S MAIDEN NAME Jane Dorsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Lucy Ennis Rock Hall, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis DUE TO (c) Myocarditis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1 - 1956, to July 25, 1956, that I last saw the deceased alive on July 24 - 1956, and that death occurred at 1:30 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert C. Nitch M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Rock Hall Maryland			
PHYSICIAN'S NAME (Type) Norbet C Nitch				Rock Hall, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 28/56		22c. NAME OF CEMETERY OR CREMATORY Sharptown Cemetery		22d. LOCATION (City, town, or county) (State) Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Marvin V. Williams Chestertown, Md.				24a. REC'D BY REGISTRAR DATE 7/28/56		24b. REGISTRAR'S SIGNATURE S. Shorrock Rogers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

AUG 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07288

7315

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH a. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CHESTERTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus			
c. LENGTH OF STAY IN 1b 1 day				d. STREET ADDRESS 1236 Leeds Terrace			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FRANCIS J. WRIGHT				4. DATE OF DEATH JULY 14 1956			
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC 6-1922	
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months 7 Days 18		IF UNDER 24 HRS. Hours 18 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bread Baker				10b. KIND OF BUSINESS OR INDUSTRY Baking Business			
11. BIRTHPLACE (State or foreign country) Shannon Pt. Md				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Fred Helmer (Foster Father)				14. MOTHER'S MAIDEN NAME Anna Hill (Foster Mother)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 216-18-9126			
17. INFORMANT Anna Hill Helmer				Address Above Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH None							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. DROWNED while sunning at Talcharter Beach, Md.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY 7:30 p.m. 7/14 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bay shore		20f. (City or town) New Chestertown Kent Md (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Robert W. Farr				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) ROBERT W. FARR				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/18/56		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or county) Woodlawn P.O. Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Inc				ADDRESS 1217 St. Paul St. Balto. Md.			
24a. REC'D BY REGISTRAR 7/18/56				24b. REGISTRAR'S SIGNATURE J. Elmer Bragg			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JUL 23 1956

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